

Arizona GROUP XXXXX

Dental Claims Audit – Draft Report

Administrator: **Delta Dental of Arizona**

Audit Period: Claims Incurred - January 1, XXXX through December 31, XXXX

Claims Paid - January 1, XXXX through January 31, XXXX

Table of Contents

Executive Summary.....	2
Audit Report Card.....	3
Audit Results Detail.....	5
Action Items.....	8
Conclusion.....	9
Appendix A - Audit Scope and Methodology.....	10
Appendix B – Review Components.....	11

Executive Summary

Overview

XXXXXXXXXX Group engaged Conduent Business Services (Conduent) to conduct a dental plan claim audit on behalf of the XXXXXXXXXXXXXXXX. The audit objective as outlined in the statement of work was to review the compliance of Delta Dental with the Plan as described in the XXXX Summary Plan Description (SPD), Administrative Service Agreement (ASA) and other documents as provided throughout the project.

A data file of all dental claims incurred from January 1, 2014 – December 31, 2015 and paid from January 1, 2014 – January 31, 2016 was provided by Delta Dental of Arizona (Delta Dental) and used for the sampling process. The scope of the audit included a high-level overview of Delta Dental's administrative procedures based on a Pre-audit questionnaire. The information provided in this questionnaire was used in Conduent's detailed evaluation of the audit samples as a guide for the review and comparison with industry standards and internal process guidelines.

The methodology utilized for completing this project was a stratified, random selection of claims to create the overall audit sample to be reviewed. Using a maximum expected error rate of 5%, 213 claims were randomly selected within seven strata, along with ten of the highest dollar claims within an additional materiality stratum to afford 95% confidence that the sample error rate would not differ by more than three percentage points from the actual error rate. During the site audit phase, the auditor reviewed the audit samples via remote virtual audit. Results from this review are being reported in the following categories:

- **Financial Accuracy:** Aggregation of all dollar amounts in the population paid correctly, divided by the total dollar amount of the population. ($\text{\$}\text{\$}\text{\$} \text{ paid correctly} / \text{Total } \text{\$}\text{\$}\text{\$} \text{ paid} = \text{Financial Accuracy \%}$).
- **Claims Processing Accuracy:** Number of confirmed claims containing neither a procedural nor a payment error, reported as a percentage of the total number of claims in the population. ($\text{\# processed correctly} / \text{Total \# claims} = \text{Processing Accuracy \%}$).
- **Procedural Accuracy:** Number of confirmed claims containing no procedural (i.e., documentation) and/or coding errors reported as a percentage of the total number of claims in the sample. ($\text{\# processed correctly} / \text{Total \# claims} = \text{Procedural Accuracy \%}$).

This statistical audit resulted in no errors. This indicates that Delta Dental's financial accuracy is 100%, which is considered above industry standards. Conduent did not identify any errors (combination of financial and non-financial errors). This indicates that Delta Dental's overall accuracy is 100%, which is considered above industry standards. No procedural errors were identified in this audit indicating that Delta Dental's procedural accuracy is 100%, which is considered above industry standards. Conduent confirmed that there were no performance guarantees for accuracy in the ASA. These results are compared to industry standards in the following Audit Report Card.

Audit Report Card

Audit Period: Incurred 1/1/2014 – 12/31/2015 and Paid 1/1/2014 – 1/31/2016									
Audit Results	# PPC	\$ PPC	Audit Results	ASA Performance Guarantee	Industry Standard	Paid Correctly	Paid in Error	Extrapolated Accuracy	Rating
Total Plan Paid Claims (PPC)	403,982	\$71,643,032	Financial Accuracy			\$118,099	\$0	\$0	
Audit Sample	223	\$118,099	Percentage	N/A	99.00%	100.00%	\$0	100.00%	+
Percent of PPC	0.06%	0.16%	Claims Processing Accuracy			223	0	0	
Correct Claims	223	\$118,099	Percentage	N/A	97.00%	100.00%	0.00%	100.00%	+
Claim Errors	0	\$0	Procedural Accuracy			223	0	0	
			Percentage	N/A	95.00%	100.00%	0.00%	100.00%	+
Errors by Stratum Reviewed Amount		Number of Audit Samples in Strata	Number of Errors in Strata	% of Sample	Financial Errors	Total # Claims in Strata Population	Total PPC in Strata Population	Extrapolated Financial Error in Strata Population	
Stratum	Audit Sample PPC by Strata								
0	\$0	10	0	0.00%	\$0	39,262	\$0	\$0	
1	\$4,666.60	60	0	0.00%	\$0	152,698	\$11,936,852	\$0	
2	\$2,238.60	17	0	0.00%	\$0	87,843	\$11,936,779	\$0	
3	\$3,900.60	21	0	0.00%	\$0	62,602	\$11,936,939	\$0	
4	\$12,699.80	34	0	0.00%	\$0	32,957	\$11,937,045	\$0	
5	\$18,743.20	28	0	0.00%	\$0	18,626	\$11,936,895	\$0	
6	\$53,399.00	43	0	0.00%	\$0	9,984	\$11,936,071	\$0	
7	\$22,451.40	10	0	0.00%	\$0	10	\$22,451	\$0	
Total	\$118,099.20	223	0	0.00%	\$0	403,982	\$71,643,032	\$0	

The remote virtual audit included a review of all processes and documentation Conduent deemed necessary to determine financial and claims processing accuracy in accordance with industry standards. Conduent confirmed that XXXXXXXXXX did not have ASA performance guarantees; therefore, only industry standards were utilized for comparisons. During the one-week site audit, Conduent conducted a high-level review of the Delta Dental 's claim processes based on pre-audit questionnaire responses. Conduent utilized the information gathered through this pre-audit questionnaire when reviewing the claims selected. Any area where the actual processing of a claim appears to differ from the administrators claim process description is outlined within the audit results section of this report.

Conduent conducted the claims review and any identified issues or errors were detailed and presented to Delta Dental for response. Delta Dental provided responses and additional documentation as requested. A meeting was held on the final day of the site audit to review the preliminary findings and discuss next steps.

Definition of “Error”

In order to maintain consistency and meet the project objectives, Conduent utilized the following definition of “error”:

An “error” is defined as, the overpayment, underpayment or procedurally incorrect payment of a claims transaction that occurs through the fault of the claims administrator. The dollar value of payment errors will be the absolute value of the error (not the net difference). Procedural errors with no financial impact include, but are not limited to, incorrect payee, insufficient documentation and coding or classification errors.

The following item will not be counted as an error:

- Errors, for which, corrective action has been taken by the claims administrator during the normal course of business within the audit period. However, errors may be assessed on claims selected for an audit if, in the judgment of the independent auditor, the error was detected and/or corrective action was taken subsequent to the administrator’s receipt of the claims audit listing or subsequent to the audit period.

Financial Accuracy

Financial accuracy values are calculated as the absolute value of the overpayments and underpayments in each stratum divided by the number of claims audited in the stratum. This result is then multiplied by the total number of claims in the population of claims that were eligible for audit (i.e., the claim population for the stratum during the audit period). The extrapolated dollar value of financial errors is the product of the stratum values. Financial accuracy for the audit sample is calculated as:

$$(\$71,643,302 - \$0) \div \$71,643,021 = 100\%$$

The financial accuracy of 100.00% is above the industry standard of 99%.

Calculation of Financial Accuracy (Absolute Value)						
Stratum	Number of Claims in Sample	Total \$ Error in Sample	Average \$ Error in Sample	Number of Claims in Population	Extrapolated \$ Error in Population	Total \$ in Population
0	10	\$0.00	\$0.00	39,262	\$0.00	\$0.00
1	60	\$0.00	\$0.00	152,698	\$0.00	\$11,936,852
2	17	\$0.00	\$0.00	87,843	\$0.00	\$11,936,779
3	21	\$0.00	\$0.00	62,602	\$0.00	\$11,936,939
4	34	\$0.00	\$0.00	32,957	\$0.00	\$11,937,045
5	28	\$0.00	\$0.00	18,626	\$0.00	\$11,936,895
6	43	\$0.00	\$0.00	9,984	\$0.00	\$11,936,071
7	10	\$0.00	\$0.00	10	\$0.00	\$22,451
Total	223	\$0.00	\$0.00	403,982	\$0.00	\$71,643,032
Financial Accuracy						100.00%

Claim Processing Accuracy

Claims processing accuracy is calculated using the average rate of error values derived by dividing the number of claims containing an error in each stratum by the number of claims audited in that stratum. The extrapolated number of claims in error is the product of the average rate of error and the total number of claims in the population based upon the population of claims that were eligible for audit (i.e., the claim population for the stratum during the audit period).

Claims processing accuracy for the audit sample is calculated as:

$$(403,982 - 0) \div 403,982 = 100\%$$

The claims processing accuracy of 100.00% is above the industry standard of 97%.

Calculation of Claims Processing Accuracy Rate					
Stratum	Number of Claims in Sample	Number of Claims With an Error	Average Rate of Error	Number of Claims in Population	Extrapolated # of Claims With Errors
0	10	0	0	39,262	0
1	60	0	0	152,698	0
2	17	0	0	87,843	0
3	21	0	0	62,602	0
4	34	0	0	32,957	0
5	28	0	0	18,626	0
6	43	0	0	9,984	0
7	10	0	0	10	0
Total	223	0	0	403,982	0
Claims Processing Accuracy					100.00%

Procedural Accuracy

Procedural accuracy is calculated using the average rate of error values derived by dividing the number of claims containing an error in each stratum by the number of claims audited in that stratum. The extrapolated number of claims in error is the product of the average rate of error and the total number of claims in the population based upon the population of claims that were eligible for audit (i.e., the claim population for the stratum during the audit period).

Procedural accuracy for the audit sample is calculated as:

$$(403,982 - 0) \div 403,982 = 100\%$$

The procedural accuracy of 100.00% is above the industry standard of 95%.

Calculation of Procedural Accuracy Rate					
Stratum	Number of Claims in Sample	Number of Claims With an Error	Average Rate of Error	Number of Claims in Population	Extrapolated # of Claims With Errors
0	10	0	0	39,262	0
1	60	0	0	152,698	0
2	17	0	0	87,843	0
3	21	0	0	62,602	0
4	34	0	0	32,957	0
5	28	0	0	18,626	0
6	43	0	0	9,984	0
7	10	0	0	10	0
Total	223	0	0	403,982	0
Procedural Accuracy					100.00%

Action Items

No errors were identified during the audit. All claims processed in accordance with the Plan documents.

No further action is required.

Conclusion

The random, stratified audit of XXXXXXXXXX's dental Plan payments administered by Delta Dental confirmed the following accuracy totals:

- The financial accuracy percentage is 100.00%, which is above industry standards.
- The claim processing accuracy is 100.00%, which is above industry standards.
- The procedural accuracy is 100.00%, which is above industry standards.

Conduent found Delta Dental's claim management to be above the target for financial, claim processing and procedural accuracy. Conduent would like to thank Delta Dental for its cooperation and active participation during the audit and thanks XXXXXXXXXX for the opportunity to have conducted this review on its behalf.

Appendix A - Audit Scope and Methodology

As stated in the Executive Summary, the methodology utilized for completing this project was a stratified random selection of claims to create the overall audit sample to be reviewed. Conduent received a claims data file from Delta Dental for the audit period. Conduent then divided paid claims for the audit period into various strata to allow for a representative review of the various types of services. Additionally, Conduent selected 10 claims for which no payment was made (i.e., applied to deductible or denied) in order achieve a representative sample of denied/deductible claims and 10 of the highest dollar claims due to the increased financial risk for this category. Using a maximum expected error rate of 5%, Conduent randomly selected 213 claims (including zero-dollar paid claims) within seven strata and 10 of the highest dollar claims in the materiality stratum to afford 95% confidence the sample error rate would not differ by more than three percentage points from the actual error rate. Precision and reliability levels (i.e., statistical assurance) affect the size of samples. This analysis provided due consideration to the frequency and processing complexity of claims that are similarly grouped (i.e., claims in the lower dollar amount stratum represented exams, x-rays and basic restorations, the majority of all claim submissions). The higher dollar stratum represented less frequent major services such as crowns and dentures. The stratification of the sample was as follows:

Neyman Allocation								
Stratum	Min	Max	Total Paid	A Total Claims	B Std. Dev.	C= (A*B) Nh * Std. Dev	Sample Distribution % Distribution	# of Claims
0	\$ 0	\$ 0	\$ 0	39,262	-			10
1	\$ 0.07	\$ 119.00	\$ 11,936,851.95	152,698	\$ 26.3713	4,026,844	29.14%	60
2	\$ 119.00	\$ 162.00	\$ 11,936,779.29	87,843	\$ 13.5426	1,189,622	8.61%	17
3	\$ 162.00	\$ 246.40	\$ 11,936,939.29	62,602	\$ 22.5017	1,408,653	10.19%	21
4	\$ 246.40	\$ 484.50	\$ 11,937,044.69	32,957	\$ 70.5380	2,324,722	16.82%	34
5	\$ 484.50	\$ 848.00	\$ 11,936,894.53	18,626	\$ 103.5237	1,928,232	13.95%	28
6	\$ 848.00	\$ 2,125.00	\$ 11,936,070.78	9,984	\$ 294.7182	2,942,466	21.29%	43
			\$ 71,620,580.53	403,972	\$ 531.20	13,820,539	100.00%	213
Top 10	\$2,127.00	\$ 2,562.00	\$ 22,451.40	10	\$ 154.80			10
	\$ 0.07	\$ 2,562.00	\$ 71,643,031.93	403,982				223

Appendix B – Review Components

Process Review

Process Review
Standard operating policies for benefit exceptions
Process for specialist referrals, pre-certification and dental authorizations linked to the claim adjudication process
Member enrollment/termination process, including maintenance and classification of student status, disabled status and COBRA participation
Coordination of benefits (COB) identification and claim adjustment process
Manual claim adjudication process, if any
Claim authorization or automatic audit thresholds (i.e., processor, supervisor, etc.)
Subrogation identification and follow-up process
Claim adjustment process
Variables specific to claim type (e.g., HCFA)

Conduent evaluated each audit sample for specific elements necessary to ensure the proper adjudication of each claim. This review encompassed but was not limited to the following components as applicable to each claim:

Audit Sample Review Components

Review Component	Review Objective
Eligibility	Validate claimant meets definition of eligible participant/dependent and identify applicable benefit plan
Coordination of Benefits	Validate other coverage and payment according to correct order of benefit determination and calculation in accordance with SPD provisions
Appropriateness of Service	Validate service rendered/billed appears reasonable and necessary
Supplemental Documentation	Validate that investigation documentation is sufficient to uphold payment (i.e., date of prior placement prosthesis, x-rays, dental consultant review) and that supplemental system informational screens (i.e. tooth charts) were updated accordingly
Provider Identification	Validate data entry of provider physical and billing address, tax identification number, patient account number, assignment of benefits and provider network status
Provider Contract Pricing	Validate pricing in accordance with provider contract
Dates of Service	Validate correct dates of service are entered for claim processing from provider claim

Date Received	Validate received date is affixed to claim and correctly entered on claim system
Coding	Validate correct data entry of provider billed information (i.e., procedure, diagnosis, internal codes and number of units)
Application of Benefits	Validate benefits were correctly applied to claim such as deductible, coinsurance, copayments, limitations, exclusions and Plan maximums
Duplicates	Validate claim payment was not duplicated and that appropriate edits and overrides were used
Subrogation/Third-Party Liability	Validate third-party liability investigation and follow-up, if applicable
Prior Authorization	Validate services were authorized in accordance with applicable Plan provisions
Cost Containment	Validate cost containment measures (i.e., large case management, negotiated services, etc.) were followed, if applicable
Remark Codes	Validate remark codes were correctly applied to claim
Override Codes	Validate any overrides were necessary and correct
UCR	Validate industry standards and internal guidelines are followed for the adjudication of non-network claims
EOB/Check Issuance/ Assignment of Benefits	Validate explanation of benefits (EOB) and payment instrument match claim processing and assignment to correct payee